# PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

## Responsible Party ( if someone other than the patient )

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

## Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

### Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

### Section 3

EFFECTIVE DATE _____

SINGLE/FAMILY COV _____

EMERGENCY CONTACT _____

## Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

## Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

TREY VEREEN, DMD

# Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

| | | | |
|---|---|---|---|
| Are you under a physician's care now? | Yes No | If yes | |
| Have you ever been hospitalized or had a major operation? | Yes No | If yes | |
| Have you ever had a serious head or neck injury? | Yes No | If yes | |
| Are you taking any medications, pills, or drugs? | Yes No | If yes | |
| Do you take, or have you taken, Phen-Fen or Redux? | Yes No | If yes | |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | Yes No | If yes | |
| Are you on a special diet? | Yes No | | |
| Do you use tobacco? | Yes No | | |
| Do you use controlled substances? | Yes No | If yes | |

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

| | | | |
|---|---|---|---|
| ☐ Aspirin | ☐ Penicillin | ☐ Codeine | ☐ Acrylic |
| ☐ Metal | ☐ Latex | ☐ Sulfa Drugs | ☐ Local Anesthetics |

Other? ☐ If yes

Do you have, or have you had, any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | Yes No | Cortisone Medicine | Yes No | Hemophilia | Yes No | Radiation Treatments | Yes No |
| Alzheimer's Disease | Yes No | Diabetes | Yes No | Hepatitis A | Yes No | Recent Weight Loss | Yes No |
| Anaphylaxis | Yes No | Drug Addiction | Yes No | Hepatitis B or C | Yes No | Renal Dialysis | Yes No |
| Anemia | Yes No | Easily Winded | Yes No | Herpes | Yes No | Rheumatic Fever | Yes No |
| Angina | Yes No | Emphysema | Yes No | High Blood Pressure | Yes No | Rheumatism | Yes No |
| Arthritis/Gout | Yes No | Epilepsy or Seizures | Yes No | High Cholesterol | Yes No | Scarlet Fever | Yes No |
| Artificial Heart Valve | Yes No | Excessive Bleeding | Yes No | Hives or Rash | Yes No | Shingles | Yes No |
| Artificial Joint | Yes No | Excessive Thirst | Yes No | Hypoglycemia | Yes No | Sickle Cell Disease | Yes No |
| Asthma | Yes No | Fainting Spells/Dizziness | Yes No | Irregular Heartbeat | Yes No | Sinus Trouble | Yes No |
| Blood Disease | Yes No | Frequent Cough | Yes No | Kidney Problems | Yes No | Spina Bifida | Yes No |
| Blood Transfusion | Yes No | Frequent Diarrhea | Yes No | Leukemia | Yes No | Stomach/Intestinal Disease | Yes No |
| Breathing Problems | Yes No | Frequent Headaches | Yes No | Liver Disease | Yes No | Stroke | Yes No |
| Bruise Easily | Yes No | Genital Herpes | Yes No | Low Blood Pressure | Yes No | Swelling of Limbs | Yes No |
| Cancer | Yes No | Glaucoma | Yes No | Lung Disease | Yes No | Thyroid Disease | Yes No |
| Chemotherapy | Yes No | Hay Fever | Yes No | Mitral Valve Prolapse | Yes No | Tonsillitis | Yes No |
| Chest Pains | Yes No | Heart Attack/Failure | Yes No | Osteoporosis | Yes No | Tuberculosis | Yes No |
| Cold Sores/Fever Blisters | Yes No | Heart Murmur | Yes No | Pain in Jaw Joints | Yes No | Tumors or Growths | Yes No |
| Congenital Heart Disorder | Yes No | Heart Pacemaker | Yes No | Parathyroid Disease | Yes No | Ulcers | Yes No |
| Convulsions | Yes No | Heart Trouble/Disease | Yes No | Psychiatric Care | Yes No | Venereal Disease | Yes No |
| | | | | | | Yellow Jaundice | Yes No |

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

# Trey Vereen, DMD PA 1522 Two Notch Rd SE Aiken, SC 29803

## Authorization Form for Use or Disclosure of Patient Information

Patient Name:_____

Patient's Date of Birth:_____ Patient's Chart No.: _____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Purpose(s) of this use or disclosure: To disclose dental information to appointed patient representative(s) and/or other dental care providers in the case of referred treatment.

The following person(s) may receive this patient information:

_____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at **Trey Vereen, DMD**. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

**Signature of Patient or Patient's Personal Representative:**

_____Date_____

If Personal Representative:

Print Name:_____

Signature:_____Relationship to Patient:_____

# OFFICE POLICY

## Trey Vereen, DMD

## Revised March, 2019

**Welcome to my practice of Family & Cosmetic Dentistry. My staff and I are pleased that you have given us the opportunity to provide your dental care. To inform you of our policy regarding appointments and the collection of fees, please read both sides of this letter and sign where indicated. If you have any questions feel free to let us know.**

## APPOINTMENTS

General – We recommend that your first appointment be made with our hygienist. This will allow the doctor to treatment plan your dental needs. We encourage our patients to schedule their hygiene appointments in advance as indicated by our hygienist. This will help to ensure that you are seen on a regular basis and that we are meeting your specific dental needs. However, if you are unable to schedule in advance, we will send you a card to remind you to call for an appointment.

CLINICAL TREATMENT – Once our treatment plan is established, we encourage you to schedule an appointment as soon as possible so that an emergency visit may be avoided. If there are questions regarding treatment, either my assistant or I will be happy to answer them in the treatment room; however, once the treatment begins, we ask that family members wait in the waiting room. This allows the doctor to concentrate on the patient. Our experience with children indicates that they do better whenever parents remain in the waiting room.

CONFIRMATION – As a courtesy to our patients, our office will try to confirm your appointment at least one business day in advance. Please let us know on the registration form any special requests or preferences regarding methods to be used to confirm your appointment.

CANCELLATION – It is the patient's responsibility to contact us if an appointment cannot be kept. We ask that **at least one business day notice** be given. However, we realize that emergencies and illness can happen without warning, so please call us as soon as possible. All communications regarding an appointment are documented in the patient's chart. **After two consecutive appointments missed or "no-showed", an up-front, non-refundable $100 deposit will be required to make a third appointment.** This deposit will go towards planned treatment, or be forfeited if this last appointment is again missed.

## REGISTRATION

REGISTRATION – The patient's name should be written without abbreviation, and the date of birth given. Please fill out this form completely except for the insurance information section. Our staff will do that for you. On each visit you will be asked to verify all the information on your registration form.

RESPONSIBLE PARTY – If someone other than the patient is responsible for the account, that section must be completed and signed by that person. Statements, refunds, in the case of overpayment, will be

sent to the responsible party. We will not assume that the person providing insurance for the patient will also be the responsible party, unless it is so declared by the patient.

## COLLECTION – INSURANCE

DENTAL INSURANCE – Even though our practice is an in-network provider for several PPOs, we still offer the service of filing any insurance claim as a courtesy to our patients. However, we ask that you **review the guidelines** of your insurance coverage every year, especially if you experience a change in your employment, or your insurance carrier. Please make us aware of any changes, so that your claim may be processed without delay. We will verify your coverage and receive a breakdown of benefits, however, without prior notice, we will be unable to accomplish this before treatment. **IN THIS CASE, THE PATIENT WILL BE REQUIRED TO PAY FOR SERVICES AT THE TIME OF TREATMENT AND RECEIVE AN INSURANCE REIMBURSEMENT LATER.**

Dental plans have become very complex and changeable, and our office cannot be held responsible for knowing all the particulars of the many plans. However, we desire that all our patients receive the maximum insurance benefit, so for major treatment plans, a pre-determination will be filed with your insurance. Our office strives to make treatment plans affordable for all our patients, using all available insurance benefits possible. **However, all patients should expect that their patient portion or deductible would be collected at the time of their treatment visit.**

## COLLECTION – NO INSURANCE

**Fees are expected to be paid when services are rendered.** Our office staff will be happy to pre-determine an estimate fee for your treatment at your request. **Please be prepared each visit to remit your portion due.** We accept cash, check, Care Credit, Visa, MasterCard, and Discover credit cards.

FRAUDULENT CHECKS – Checks returned for any reason will be assessed a penalty totaling the bank return fee. The patient will be notified and will be expected to clear the account with cash, credit card or money order within 10 days.

COLLECTION COST – Accounts are considered past due if a patient fails to remit their balance within 30 days of receiving a statement. Past due accounts will be assessed a MINIMUM collection fee of 35% of the balance owed. This fee may increase if the doctor incurs additional cost for collection involving a collection service, magistrate's court or lawyer fees. Patients with delinquent account are subject to refusal of further treatment.

**Our office is in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Patients and/or their guardian can request a copy of our "Notice of Privacy Practices" and will be required to sign our "Consent for Use and Disclosure of Health Information" form either giving consent or refusal regarding the privacy of their information. This form is permanently placed in the patient's records.**

Please sign below indicating that you have read this form and will comply with the above policies.

_____ Date____/____/____

Signature of Responsible Party/Patient

# Epworth Sleepiness Scale[11]

How likely are you to nod off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently, try to work out how they would have affected you. It is important that you answer each question as best you can.

Use the following scale to choose the most appropriate number for each situation.

| | Would never nod off<br>0 | Slight chance of nodding off<br>1 | Moderate chance of nodding off<br>2 | High chance of nodding off<br>3 |
|---|---|---|---|---|
| **Sitting and reading** | | | | |
| **Watching TV** | | | | |
| **Sitting, inactive**, in a public place (e.g., in a meeting, theater, or dinner event) | | | | |
| **As a passenger in a car** for an hour or more without stopping for a break | | | | |
| **Lying down to rest** when circumstances permit | | | | |
| **Sitting and talking** to someone | | | | |
| **Sitting quietly** after a meal without alcohol | | | | |
| **In a car, while stopped** for a few minutes in traffic or at a light | | | | |

Add up your points to get your total score. A score of 10 or greater raises concern: you may need to get more sleep, improve your sleep practices, or seek medical attention to determine why you are sleepy.